Subpart D—Limitation on Charges for Services Furnished by Medicare-Participating Hospitals to Indians

SOURCE: 72 FR 30710, June 4, 2007, unless otherwise noted.

§ 136.30 Payment to Medicare-participating hospitals for authorized Contract Health Services.

(a) *Scope.* All Medicare-participating hospitals, which are defined for purposes of this subpart to include all departments and provider-based facilities of hospitals (as defined in sections 1861(e) and (f) of the Social Security Act) and critical access hospitals (as defined in section 1861(mm)(1) of the Social Security Act), that furnish inpatient services must accept no more than the rates of payment under the methodology described in this section as payment in full for all items and services authorized by IHS, Tribal, and urban Indian organization entities, as described in paragraph (b) of this section.

(b) *Applicability.* The payment methodology under this section applies to all levels of care furnished by a Medicare-participating hospital, whether provided as inpatient, outpatient, skilled nursing facility care, as other services of a department, subunit, distinct part, or other component of a hospital (including services furnished directly by the hospital or under arrangements) that is authorized under part 136, subpart C by a contract health service (CHS) program of the Indian Health Service (IHS); or authorized by a Tribe or Tribal organization carrying out a CHS program of the IHS under the Indian Self-Determination and Education Assistance Act, as amended, Pub. L. 93–638, 25 U.S.C. 450 *et seq.*; or authorized for purchase under §136.31 by an urban Indian organization (as that term is defined in 25 U.S.C. 1603(h)) (hereafter ''I/T/U'').

(c) *Basic determination.* (1) Payment for hospital services that the Medicare program would pay under a prospective payment system (PPS) will be based on that PPS. For example, payment for inpatient hospital services shall be made per discharge based on the applicable PPS used by the Medicare program to pay for similar hospital services under 42 CFR part 412. Payment for outpatient hospital services shall be made based on a PPS used in the Medicare program to pay for similar hospital services under 42 CFR part 419. Payment for skilled nursing facility (SNF) services shall be based on a PPS used in the Medicare program to pay for similar SNF services under 42 CFR part 413.

(2) For Medicare participating hospitals that furnish inpatient services but are exempt from PPS and receive reimbursement based on reasonable costs (for example, critical access hospitals (CAHs), children's hospitals, cancer hospitals, and certain other hospitals reimbursed by Medicare under special arrangements), including provider subunits exempt from PPS, payment shall be made per discharge based on the reasonable cost methods established under 42 CFR part 413, except that the interim payment rate under 42 CFR part 413, subpart E shall constitute payment in full for authorized charges.

(d) *Other payments.* In addition to the amount payable under paragraph (c)(1) of this section for authorized inpatient services, payments shall include an amount to cover: The organ acquisition costs incurred by hospitals with approved transplantation centers; direct medical education costs; units of blood clotting factor furnished to an eligible patient who is a hemophiliac; and the costs of qualified non-physician anesthetists, to the extent such costs would be payable if the services had been covered by Medicare. Payment under this subsection shall be made on a per discharge basis and will be based on standard payments established by the Centers for Medicare & Medicaid Services (CMS) or its fiscal intermediaries.

(e) *Basic payment calculation.* The calculation of the payment by I/T/Us will be based on determinations made under paragraphs (c) and (d) of this section consistent with CMS instructions to its fiscal intermediaries at the time the claim is processed. Adjustments will be made to correct billing or claims processing errors, including when fraud is detected. I/T/Us shall pay the providing hospital the full PPS based rate, or the interim reasonable cost rate, without

reduction for any co-payments, coinsurance, and deductibles required by the Medicare program from the patient.

(f) *Exceptions to payment calculation.* Notwithstanding paragraph (e) of this section, if an amount has been negotiated with the hospital or its agent by the I/T/U, the I/T/U will pay the lesser of: The amount determined under paragraph (e) of this section or the amount negotiated with the hospital or its agent, including but not limited to capitated contracts or contracts per Federal law requirements;

(g) *Coordination of benefits and limitation on recovery.* If an I/T/U has authorized payment for items and services provided to an individual who is eligible for benefits under Medicare, Medicaid, or another third party payor—

(1) The I/T/U shall be the payor of last resort under §136.61;

(2) If there are any third party payers, the I/T/U will pay the amount for which the patient is being held responsible after the provider of services has coordinated benefits and all other alternative resources have been considered and paid, including applicable co-payments, deductibles, and coinsurance that are owed by the patient; and

(3) The maximum payment by the I/T/U will be only that portion of the payment amount determined under this section not covered by any other payor; and

(4) The I/T/U payment will not exceed the rate calculated in accordance with paragraph (e) of this section or the contracted amount (plus applicable cost sharing), whichever is less; and

(5) When payment is made by Medicaid it is considered payment in full and there will be no additional payment made by the I/T/U to the amount paid by Medicaid (except for applicable cost sharing).

(h) *Claims processing.* For a hospital to be eligible for payment under this section, the hospital or its agent must submit the claim for authorized services—

(1) On a UB92 paper claim form (until abolished, or on an officially adopted successor form) or the HIPAA 837 electronic claims format ANSI X12N, version 4010A1 (until abolished, or on an officially adopted successor form) and include the hospital's Medicare provider number/National Provider Identifier; and

(2) To the I/T/U, agent, or fiscal intermediary identified by the I/T/U in the agreement between the I/T/U and the hospital or in the authorization for services provided by the I/T/U; and

(3) Within a time period equivalent to the timely filing period for Medicare claims under 42 CFR 424.44 and provisions of the Medicare Claims Processing Manual applicable to the type of item or service provided.

(i) *Authorized services.* Payment shall be made only for those items and services authorized by an I/T/U consistent with part 136 of this title or section 503(a) of the Indian Health Care Improvement Act (IHCIA), Public Law 94–437, as amended, 25 U.S.C. 1653(a).

(j) *No additional charges.* A payment made in accordance with this section shall constitute payment in full and the hospital or its agent may not impose any additional charge—

(1) On the individual for I/T/U authorized items and services; or

(2) For information requested by the I/T/U or its agent or fiscal intermediary for the purposes of payment determinations or quality assurance.

§136.31 Authorization by urban Indian organization.

An urban Indian organization may authorize for purchase items and services for an eligible urban Indian (as those terms are defined in 25 U.S.C. 1603(f) and (h)) according to section 503 of the IHCIA and applicable regulations. Services and items furnished by Medicare-participating inpatient hospitals shall be subject to the payment methodology set forth in §136.30.

§136.32 Disallowance.

(a) If it is determined that a hospital has submitted inaccurate information for payment, such as admission, discharge or billing data, an I/T/U may as appropriate—

(1) Deny payment (in whole or in part) with respect to any such services, and;

(2) Disallow costs previously paid, including any payments made under any methodology authorized under this subpart. The recovery of payments